EXHIBIT 4

AUTHORIZATION FOR RELEASE OF MEDICAL & BILLING INFORMATION

TO: The physician, psychologist, hospital, medical provider, insurance company, private or third party payor, and/or their custodians of records:

_____
Medical Facility

_____
Address

This is authority for you to furnish to Eric Schwarz, Vice President, Rust Consulting/Omni Bankruptcy, 5955 Desoto Avenue, Suite 100, Woodland Hills, CA 91367, upon presentation of this authorization, all information, including but not limited to medical, billing and/or business records, concerning the past, present, or future physical condition of_____ ("Patient"), including full disclosure of all hospitalizations, treatments, medical records, reports, diagnostic studies, x-rays, histories, charts, and any other documentation, as well as information concerning costs and expenses incurred for treatment from **January 1, 2007 to date**..

The release of the matters listed above is being authorized for purposes of litigation. .

The undersigned understands that, with respect to this Authorization:

- the signing of this Authorization is strictly voluntary;
- treatment, enrollment, or eligibility for, or payment of, benefits may not be conditioned upon the signing of this authorization;
- the released information may be subject to redisclosure by the recipient in conjunction with this litigation and may no longer be protected by federal or state privacy laws or regulations;
- the undersigned is entitled to examine and/or obtain a copy of the information described in this Authorization, for a reasonable copy fee, if requested from the covered entity receiving this Authorization; and
- the information released may consist of information regarding HIV testing and results, or information about AIDS.

This authorization explicitly excludes ex parte communications with the undersigned's healthcare providers.

This authorization is subject to revocation by the undersigned, if said revocation is in writing addressed to the above-named **Medical Facility**, at any time, and if not earlier revoked, shall terminate at the conclusion of the undersigned's lawsuit. . A photostatic copy of this Authorization is as valid and binding as an original executed by the undersigned. This authorization complies with 45 CFR 164 regarding the core elements of an authorization pursuant to HIPAA.

The undersigned acknowledges that he/she is the individual whose protected health information is being released, or is a person authorized to act on that individual's behalf.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

[Signature of Patient or Representative] **[Date of Authorization]**

_____

[Print Name of Patient or Representative]

Last Four Digits of Social Security Number of Patient _XXX-XX-_____

Date of Birth of Patient _____

If executed by a Representative, state the relationship of Representative to

Patient:_____

_____ _____

[Witness Signature] **[Date]**